Section 9: Remittance and Status Report

What Is the Remittance and Status Report?

The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted to EDS, along with a detailed breakdown of payment. The RA is produced at the same time that checks or electronic funds transfers are generated. If the RA is 10 pages or fewer for any checkwrite, it is mailed with the reimbursement check. If the RA is more than 10 pages, it is mailed under separate cover.

To assist in keeping all claims and payment records current, retain all RAs. RAs should be kept in a notebook or filed in chronological order for easy reference.

Reviewing the RA is the first step in claim resolution. If you are unable to resolve the claim by reviewing the RA or have questions concerning claims payment, contact the EDS Provider Services Unit for assistance at 1-800-688-6696 or 919-851-8888, option three.

Remittance and Status Report Sections and Subsections

The RA is composed of information identified by subject headings. Each major subject heading is further divided into subsections depending on provider types or claim type.

Paid Claims

This section shows all of the claims that were paid or partially paid since the previous checkwrite. The subsections under this section are dependent upon provider type.

The Paid Claims section for institutional RAs is subdivided into

- Inpatient claims
- Outpatient claims
- Inpatient crossover claims
- Outpatient crossover claims

The Paid Claims section for professional RAs is subdivided into

- Medical claims
- Screening claims for Health Check providers
- Crossover claims

Claims are listed in each subsection alphabetically by the recipient's last name. A subtotal follows each subsection, and the grand total follows the entire section.

Adjusted Claims

This section shows the status of claims when requests for action have been made to correct overpayment, underpayment, or payment to the wrong provider. Some of the most common causes for adjustments are clerical errors, incorrect claim information, or incorrect procedure coding. There are no subsections under this heading.

Informational Adjustment Claims

This section is on the RA to comply with regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA). This section is informational and reports data related to refunds processed by Medicaid.

Denied Claims

This section identifies claims that have been denied for payment because of various improper or incomplete claims entries. The claims listed in this section are divided into subsections to indicate the type of bill that was processed. Claims are listed in each subsection alphabetically by the recipient's last name. A zero appears in all of the columns to the right of the "Non-Allowed" column. A denial explanation code is located in the far right-hand column. No action is taken by EDS on denied claims. To resolve the denial, the providers must correct and resubmit the claim.

Claims in Process

This section lists claims that have been received and entered by EDS but are pending payment because further review of the claims is needed. Do not resubmit claims that are pending payment.

Financial Items

This section contains a listing of provider-refunded payments, recoupments, payouts, and other financial activities that have taken place for the current checkwrite. The recoupments, refunds, and other recovered items appear as credits against the provider's total earnings for the year. Payouts appear as debits against the total earnings for the year. The explanation code beside each item indicates the type of action that was taken for that item.

Claims Summary

The Claims Summary section is used only for specific providers. It is divided into inpatient and outpatient subsections. Following each subsection is a summary of the revenue code totals from all of the claims listed in each subsection.

Claims Payment Summary

This section summarizes all payments, withheld amounts, and credits made to the provider for both the current checkwrite cycle(Current Processed) and for the current year (Year to Date Total).

Financial Payer Code

A financial payer code follows the internal control number (ICN) assigned to each claim. It is located in the first line of the claim data reflected on the RA. This financial payer code denotes the entity responsible for payment of the claims listed on the RA. Medicaid is the only financially responsible payer. Therefore, only the Medicaid payer code, NCXIX, will be listed.

Population Group Payer Code

The RA reflects the population payer code for each claim detail. The population payer code is printed at the beginning of each claim detail line on the RA. The population payer code denotes the special program or population group from which a recipient is receiving Medicaid benefits.

Examples of population payer codes are as follows.

Code	Name	Description
CA-I	Carolina ACCESS	All recipients enrolled in Medicaid's Carolina ACCESS (CA) program
CA-II	ACCESS II	All recipients enrolled in Medicaid's ACCESS II (Community Care of North Carolina, or CCNC) program

Code	Name	Description
NCXIX	Medicaid	All recipients not enrolled in any of the above-noted population payer programs. Any recipient not identified with Carolina ACCESS (CCNC) or ACCESS II (CCNC) will be assigned the NCXIX population payer code to identify them with the Medicaid fee-for-service program.
PCHP	Piedmont Cardinal Health Plan	All Medicaid mental health, developmental disabilities, and substance abuse (MH/DD/SA) services for individuals receiving Medicaid from Rowan, Stanly, Union, Davidson, and Cabarrus counties are provided through PCHP.

Other population payers may be designated by DMA in the future.

New Totals Following the Current Claim Total Line

An additional line is added following each claim total line of the paid and denied claim sections of the RA for the following claim types:

- Medical (J)
- Dental (K)
- Home health, hospice, and personal care (Q)
- Medical vendor (P)
- Outpatient (M)
- Professional crossover (O)

This additional line provides a summary of the original claim billed amount, original claim detail count, and the total number of financial payers. Because they are not processed at the claim detail level and do not have multiple financial payers assigned, a summary of this information is not listed for the following claim types:

- Drug (D)
- Inpatient (S)
- Nursing home (T)

Summary Page

For each Medicaid population payer identified on the RA, a summary page showing total payments by population payer is provided at the end of the RA. This provides population payer detail information for tracking and informational purposes.

Remittance and Status Report Field Descriptions

Claims are listed alphabetically by the recipient's last name. The charge for each procedure or service billed for that recipient is listed on a separate line. Information about each charge is listed on the RA.

The following table provides an explanation of the fields on the RA.

Field	Explanation
Name	Recipient's name, listed by last name
County Number	A numeric code for the recipient's county of residence
RCC	Ratio of cost-to-charge, which indicates the percent of Total Allowed charge to be paid (where applicable)

Field	Explanation
Claim Number	The unique 20-digit ICN assigned to each claim by EDS for internal control purposes **Note:** Reference this number when corresponding with EDS about a claim.
Recipient ID	The recipient's Medicaid identification (MID) number is listed below the recipient's name.
Medical Record Number	If a provider chooses to use a medical record number when submitting a claim, the first nine characters of the number are displayed in this field. If no medical record number is entered on the claim, the RA will list the Medical Record Number as 0.
Population Group	The Population Payer Code denoting the special program or population group from which a recipient is receiving Medicaid benefits
Service Dates	The "From" (beginning) date of service and the "To" (ending) date of service, in the MMDDCCYY format
Days or Units	Number of times a particular type of service is provided within the given service dates. Depending on the provider type, either the number of days or units of service is shown. Decimal quantities are appropriate.
Type of Service (TOS)	The Medicaid conversion for the TOS billed
Procedure/Accommodation/ Drug Code and Description	The procedure, service, or drug code. For providers mandated to use modifiers when billing, the modifiers are printed below the description of service. These provider types will not show TOS except on claims for which TOS is still used (e.g., Health Check).
Total Billed	Total amount the provider bills for each procedure or service
Non Allowed	Difference between the Total Billed column and the Total Allowed column
Total Allowed	Total amount Medicaid allows for a particular procedure or service. The charge billed for each service is determined to be either a "covered charge" or a "non-covered charge." The Total Allowed is 0 for a non-covered charge. (Total Allowed = Total Billed – Non-allowed)
Payable Cutback	Difference between the Medicaid-allowed amount and the amount that Medicaid pays for a particular procedure or service based on the revenue code or reimbursement amount
Other Deducted Charges	Other sources of medical service funds must be deducted from the Payable Charge amount or cost before the Medicaid program pays the charge. These deductions include third-party liability, patient liability, and co-payment. (The deductions are listed below the claim information for each recipient.) **Note:** For hospital claims, patient liability is deducted from the Total Billed and is shown in the non-allowed column.
Paid Amount	Amount paid to the provider (Paid Amount = Payable Charge – Other Deducted Charges)
Explanation Codes	A numeric explanation code for each procedure or service billed, which shows the method of payment or reason for denial. A list of the codes and descriptions is located on the last page of the RA.

Field	Explanation
Deductible (Spend down)	The total amount of the deductible (spend down) is listed below the claim information for each recipient. This amount is applied to the Billed Amount for each procedure or service billed until the total amount of the deductible is met.
Patient Liability Co-payment Third-Party Liability	A listing of these amounts follows the claim information. These items are totaled and entered in the Other Deducted Charges column. They are deducted from the Payable Charge.
Difference	Difference between the Medicaid projected payment (a calculation of the difference between the Medicaid allowable and the Medicare payment) and the actual Medicaid payment when Medicaid pays the Medicare co-insurance or deductible
Original Detail Count	Number of items (procedures or services) billed
Total Financial Payers	Number of entities responsible for payment

Explanation of the Internal Control Number

Each claim processed by the Medicaid program is assigned a unique 20-character ICN. The ICN is used on the RA to identify the claim and to trace the claim through the processing cycle. The ICN identifies how and when EDS received the claim and how it was processed by assigning numeric codes for the following.

Field	Explanation
Region	The first two digits indicate whether the claim was submitted on paper, electronically by modem or diskette, electronically by magnetic tape, or as an adjustment.
Year	The next four digits indicate the year that the claim was received.
Julian Date	The next three digits indicate the date the claim was received in the EDS mailroom. The Julian calendar is used to identify the numerical day of the year. (For example, 001 = Jan. 1 and 365 = Dec. 31.)
Batch	The next three digits represent the identification number that is assigned to paper claims, which are batched into groups of 100 as they are received and scanned into the system.
# of Claims in Batch	The next three digits represent the number that is assigned to each claim within the batch of 100. (For example, 000 = first claim and 990 = last claim.)
Payer Code	The 5-character payer code denotes the entity responsible for payment of the claim. (For example, NCXIX = North Carolina Medicaid.)

The following table shows the region code for each type of submission and examples of how the year, Julian date, batch, number of claims, and payer code would appear.

Submission Type	Explanation of Region	Region	Year	Julian Date	Batch	# of Claims	Payer Code
Paper Submission	A paper claim received in the EDS mailroom and keyed by EDS	10	2007	001	600	000	NCXIX
Electronic Submission (PC)	Claim submitted electronically through a personal computer by either modem or mail-in diskette	25	2007	365	600	990	NCXIX

Submission Type	Explanation of Region	Region	Year	Julian Date	Batch	# of Claims	Payer Code
Electronic Submission (Tape)	Electronic claim submitted by magnetic tape	15	2007	002	600	010	NCXIX
Medicare Crossover	Medicare crossover received by EDS from Medicare on magnetic tape. If the claim is not automatically crossed over from Medicare and the provider submits the claim copy and EOB, the claim number will begin with a 10, indicating a paper claim.	40	2007	005	300	500	NCXIX
Adjustment Request	Adjustment requested by the provider, EDS, or DMA. A previous payment was made on this claim.	90 or 95	2007	300	980	100	NCXIX
Refund	Refund sent to EDS from the provider	91	2007	246	750	002	NCXIX

Explanation of Benefit Codes

The Health Care Claim Payment/Advice (835) transaction set is designed for the payment of claims and transfer of remittance information in the health care industry. N.C. Medicaid providers may receive the RA through the HIPAA-compliant 835 transaction, which converts all state explanation of benefits EOB codes to the national standard HIPAA codes. The DMA Web site provides a crosswalk table to convert the HIPAA status codes to the state EOB codes at http://www.ncdhhs.gov/dma/hipaa.htm.